26-19-1. Short title.

This chapter shall be known and may be cited as the "Medical Benefits Recovery Act."

Enacted by Chapter 126, 1981 General Session

26-19-2. Definitions.

As used in this chapter:

(1) "Annuity" shall have the same meaning as provided in Section 31A-1-301.

(2) "Claim" means:

(a) a request or demand for payment; or

(b) a cause of action for money or damages arising under any law.

(3) "Employee welfare benefit plan" means a medical insurance plan developed by an employer under 29 U.S.C. Section 1001, et seq., the Employee Retirement Income Security Act of 1974 as amended.

(4) "Estate" means, regarding a deceased recipient:

(a) all real and personal property or other assets included within a decedent's estate as defined in Section 75-1-201;

(b) the decedent's augmented estate as defined in Section 75-2-203; and

(c) that part of other real or personal property in which the decedent had a legal interest at the time of death including assets conveyed to a survivor, heir, or assign of the decedent through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.

(5) "Health insurance entity" means:

(a) an insurer;

(b) a person who administers, manages, provides, offers, sells, carries, or underwrites health insurance, as defined in Section 31A-1-301;

(c) a self-insured plan;

(d) a group health plan, as defined in Subsection 607(1) of the federal Employee Retirement Income Security Act of 1974;

(e) a service benefit plan;

(f) a managed care organization;

(g) a pharmacy benefit manager;

(h) an employee welfare benefit plan; or

(i) a person who is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

(6) "Insurer" includes:

(a) a group health plan as defined in Subsection 607(1) of the federal Employee Retirement Income Security Act of 1974;

(b) a health maintenance organization; and

(c) any entity offering a health service benefit plan.

(7) "Medical assistance" means:

(a) all funds expended for the benefit of a recipient under Title 26, Chapter 18, Medical Assistance Act, or under Titles XVIII and XIX, federal Social Security Act; and

(b) any other services provided for the benefit of a recipient by a prepaid health care delivery system under contract with the department.

(8) "Office of Recovery Services" means the Office of Recovery Services within the Department of Human Services.

(9) "Provider" means a person or entity who provides services to a recipient.

(10) "Recipient" means:

(a) a person who has applied for or received medical assistance from the state;

(b) the guardian, conservator, or other personal representative of a person under Subsection (10)(a) if the person is a minor or an incapacitated person; or

(c) the estate and survivors of a person under Subsection (10)(a) if the person is deceased.

(11) "State plan" means the state Medicaid program as enacted in accordance with Title XIX, federal Social Security Act.

(12) "Third party" includes:

(a) an individual, institution, corporation, public or private agency, trust, estate, insurance carrier, employee welfare benefit plan, health maintenance organization, health service organization, preferred provider organization, governmental program such as Medicare, CHAMPUS, and workers' compensation, which may be obligated to pay all or part of the medical costs of injury, disease, or disability of a recipient, unless any of these are excluded by department rule; and

(b) a spouse or a parent who:

(i) may be obligated to pay all or part of the medical costs of a recipient under law or by court or administrative order; or

(ii) has been ordered to maintain health, dental, or accident and health insurance to cover medical expenses of a spouse or dependent child by court or administrative order.

(13) "Trust" shall have the same meaning as provided in Section 75-1-201.

Amended by Chapter 64, 2007 General Session

26-19-3. Program established by department -- Promulgation of rules.

(1) The department shall establish and maintain a program for the recoupment of medical assistance.

(2) The department may promulgate rules to implement the purposes of this chapter.

Amended by Chapter 34, 1984 General Session

26-19-4.5. Assignment of rights to benefits.

(1) (a) To the extent that medical assistance is actually provided to a recipient, all benefits for medical services or payments from a third party otherwise payable to or on behalf of a recipient are assigned by operation of law to the department if the department provides, or becomes obligated to provide, medical assistance, regardless of who made application for the benefits on behalf of the recipient.

(b) The assignment:

(i) authorizes the department to submit its claim to the third party and authorizes payment of benefits directly to the department; and

(ii) is effective for all medical assistance.

(2) The department may recover the assigned benefits or payments in accordance with Section 26-19-5 and as otherwise provided by law.

(3) The assignment of benefits includes medical support and third party payments ordered, decreed, or adjudged by any court of this state or any other state or territory of the United States. That assignment is not in lieu of, and does not supersede or alter any other court order, decree, or judgment.

(4) When an assignment takes effect, the recipient is entitled to receive medical assistance, and the benefits paid to the department are a reimbursement to the department.

Amended by Chapter 145, 1998 General Session

26-19-4.7. Health insurance entity -- Duties related to state claims for Medicaid payment or recovery.

As a condition of doing business in the state, a health insurance entity shall:

(1) with respect to a person who is eligible for, or is provided, medical assistance under the state plan, upon the request of the Department of Health, provide information to determine:

(a) during what period the person, or the spouse or dependent of the person, may be or may have been, covered by the health insurance entity; and

(b) the nature of the coverage that is or was provided by the health insurance entity described in Subsection (1)(a), including the name, address, and identifying number of the plan;

(2) accept the state's right of recovery and the assignment to the state of any right of a person to payment from a party for an item or service for which payment has been made under the state plan;

(3) respond to any inquiry by the Department of Health regarding a claim for payment for any health care item or service that is submitted no later than three years after the day on which the health care item or service is provided; and

(4) not deny a claim submitted by the Department of Health solely on the basis of the date of submission of the claim, the type or format of the claim form, or failure to present proper documentation at the point-of-sale that is the basis for the claim, if:

(a) the claim is submitted no later than three years after the day on which the item or service is furnished; and

(b) any action by the Department of Health to enforce the rights of the state with respect to the claim is commenced no later than six years after the day on which the claim is submitted.

Enacted by Chapter 64, 2007 General Session

26-19-5. Recovery of medical assistance from third party -- Lien -- Notice -- Action -- Compromise or waiver -- Recipient's right to action protected.

(1) (a) When the department provides or becomes obligated to provide medical assistance to a recipient that a third party is obligated to pay for, the department may recover the medical assistance directly from that third party.

(b) Any claim arising under Subsection (1)(a) or Section 26-19-4.5 to recover

medical assistance provided to a recipient is a lien against any proceeds payable to or on behalf of the recipient by that third party. This lien has priority over all other claims to the proceeds, except claims for attorney's fees and costs authorized under Subsection 26-19-7(2)(c)(ii).

(2) (a) The department shall mail or deliver written notice of its claim or lien to the third party at its principal place of business or last-known address.

(b) The notice shall include:

(i) the recipient's name;

(ii) the approximate date of illness or injury;

(iii) a general description of the type of illness or injury; and

(iv) if applicable, the general location where the injury is alleged to have occurred.

(3) The department may commence an action on its claim or lien in its own name, but that claim or lien is not enforceable as to a third party unless:

(a) the third party receives written notice of the department's claim or lien before it settles with the recipient; or

(b) the department has evidence that the third party had knowledge that the department provided or was obligated to provide medical assistance.

(4) The department may:

(a) waive a claim or lien against a third party in whole or in part; or

(b) compromise, settle, or release a claim or lien.

(5) An action commenced under this section does not bar an action by a recipient or a dependent of a recipient for loss or damage not included in the department's action.

(6) The department's claim or lien on proceeds under this section is not affected by the transfer of the proceeds to a trust, annuity, financial account, or other financial instrument.

Amended by Chapter 103, 2005 General Session

26-19-6. Action by department -- Notice to recipient.

(1) (a) Within 30 days after commencing an action under Subsection 26-19-5(3), the department shall give the recipient, his guardian, personal representative, trustee, estate, or survivor, whichever is appropriate, written notice of the action by:

(i) personal service or certified mail to the last known address of the person receiving the notice; or

(ii) if no last-known address is available, by publishing a notice:

(A) once a week for three successive weeks in a newspaper of general circulation in the county where the recipient resides; and

(B) in accordance with Section 45-1-101 for three weeks.

(b) Proof of service shall be filed in the action.

(c) The recipient may intervene in the department's action at any time before trial.

(2) The notice required by Subsection (1) shall name the court in which the action is commenced and advise the recipient of:

(a) the right to intervene in the proceeding;

(b) the right to obtain a private attorney; and

(c) the department's right to recover medical assistance directly from the third party.

Amended by Chapter 388, 2009 General Session

26-19-7. Notice of claim by recipient -- Department response -- Conditions for proceeding -- Collection agreements -- Department's right to intervene -- Department's interests protected -- Remitting funds -- Disbursements -- Liability and penalty for noncompliance.

(1) (a) A recipient may not file a claim, commence an action, or settle, compromise, release, or waive a claim against a third party for recovery of medical costs for an injury, disease, or disability for which the department has provided or has become obligated to provide medical assistance, without the department's written consent as provided in Subsection (2)(b) or (4).

(b) For purposes of Subsection (1)(a), consent may be obtained if:

(i) a recipient who files a claim, or commences an action against a third party notifies the department in accordance with Subsection (1)(d) within 10 days of making the claim or commencing an action; or

(ii) an attorney, who has been retained by the recipient to file a claim, or commence an action against a third party, notifies the department in accordance with Subsection (1)(d) of the recipient's claim:

(A) within 30 days after being retained by the recipient for that purpose; or

(B) within 30 days from the date the attorney either knew or should have known that the recipient received medical assistance from the department.

(c) Service of the notice of claim to the department shall be made by certified mail, personal service, or by e-mail in accordance with Rule 5 of the Utah Rules of Civil Procedure, to the director of the Office of Recovery Services.

(d) The notice of claim shall include the following information:

(i) the name of the recipient;

(ii) the recipient's Social Security number;

(iii) the recipient's date of birth;

(iv) the name of the recipient's attorney if applicable;

(v) the name or names of individuals or entities against whom the recipient is making the claim, if known;

(vi) the name of the third party's insurance carrier, if known;

(vii) the date of the incident giving rise to the claim; and

(viii) a short statement identifying the nature of the recipient's claim.

(2) (a) Within 30 days of receipt of the notice of the claim required in Subsection (1), the department shall acknowledge receipt of the notice of the claim to the recipient or the recipient's attorney and shall notify the recipient or the recipient's attorney in writing of the following:

(i) if the department has a claim or lien pursuant to Section 26-19-5 or has become obligated to provide medical assistance; and

(ii) whether the department is denying or granting written consent in accordance with Subsection (1)(a).

(b) The department shall provide the recipient's attorney the opportunity to enter into a collection agreement with the department, with the recipient's consent, unless:

(i) the department, prior to the receipt of the notice of the recipient's claim pursuant to Subsection (1), filed a written claim with the third party, the third party agreed to make payment to the department before the date the department received notice of the recipient's claim, and the agreement is documented in the department's record; or

(ii) there has been a failure by the recipient's attorney to comply with any provision of this section by:

(A) failing to comply with the notice provisions of this section;

(B) failing or refusing to enter into a collection agreement;

(C) failing to comply with the terms of a collection agreement with the department; or

(D) failing to disburse funds owed to the state in accordance with this section.

(c) (i) The collection agreement shall be:

(A) consistent with this section and the attorney's obligation to represent the recipient and represent the state's claim; and

(B) state the terms under which the interests of the department may be represented in an action commenced by the recipient.

(ii) If the recipient's attorney enters into a written collection agreement with the department, or includes the department's claim in the recipient's claim or action pursuant to Subsection (4), the department shall pay attorney's fees at the rate of 33.3% of the department's total recovery and shall pay a proportionate share of the litigation expenses directly related to the action.

(d) The department is not required to enter into a collection agreement with the recipient's attorney for collection of personal injury protection under Subsection 31A-22-302(2).

(3) (a) If the department receives notice pursuant to Subsection (1), and notifies the recipient and the recipient's attorney that the department will not enter into a collection agreement with the recipient's attorney, the recipient may proceed with the recipient's claim or action against the third party if the recipient excludes from the claim:

(i) any medical expenses paid by the department; or

(ii) any medical costs for which the department is obligated to provide medical assistance.

(b) When a recipient proceeds with a claim under Subsection (3)(a), the recipient shall provide written notice to the third party of the exclusion of the department's claim for expenses under Subsection (3)(a)(i) or (ii).

(4) If the department receives notice pursuant to Subsection (1), and does not respond within 30 days to the recipient or the recipient's attorney, the recipient or the recipient's attorney:

(a) may proceed with the recipient's claim or action against the third party;

(b) may include the state's claim in the recipient's claim or action; and

(c) may not negotiate, compromise, settle, or waive the department's claim without the department's consent.

(5) The department has an unconditional right to intervene in an action commenced by a recipient against a third party for the purpose of recovering medical

costs for which the department has provided or has become obligated to provide medical assistance.

(6) (a) If the recipient proceeds without complying with the provisions of this section, the department is not bound by any decision, judgment, agreement, settlement, or compromise rendered or made on the claim or in the action.

(b) The department may recover in full from the recipient or any party to which the proceeds were made payable all medical assistance which it has provided and retains its right to commence an independent action against the third party, subject to Subsection 26-19-5(3).

(7) Any amounts assigned to and recoverable by the department pursuant to Sections 26-19-4.5 and 26-19-5 collected directly by the recipient shall be remitted to the Bureau of Medical Collections within the Office of Recovery Services no later than five business days after receipt.

(8) (a) Any amounts assigned to and recoverable by the department pursuant to Sections 26-19-4.5 and 26-19-5 collected directly by the recipient's attorney shall be remitted to the Bureau of Medical Collections within the Office of Recovery Services no later than 30 days after the funds are placed in the attorney's trust account.

(b) The date by which the funds shall be remitted to the department may be modified based on agreement between the department and the recipient's attorney.

(c) The department's consent to another date for remittance may not be unreasonably withheld.

(d) If the funds are received by the recipient's attorney, no disbursements shall be made to the recipient or the recipient's attorney until the department's claim has been paid.

(9) A recipient or recipient's attorney who knowingly and intentionally fails to comply with this section is liable to the department for:

(a) the amount of the department's claim or lien pursuant to Subsection (5);

(b) a penalty equal to 10% of the amount of the department's claim; and

(c) attorney fees and litigation expenses related to recovering the department's claim.

Amended by Chapter 297, 2011 General Session

26-19-8. Statute of limitations -- Survival of right of action -- Insurance policy not to limit time allowed for recovery.

(1) (a) Subject to Subsection (6), action commenced by the department under this chapter against a health insurance entity shall be commenced within:

(i) subject to Subsection (7), six years after the day on which the department submits the claim for recovery or payment for the health care item or service upon which the action is based; or

(ii) six months after the date of the last payment for medical assistance, whichever is later.

(b) An action against any other third party, the recipient, or anyone to whom the proceeds are payable shall be commenced within:

(i) four years after the date of the injury or onset of the illness; or

(ii) six months after the date of the last payment for medical assistance,

whichever is later.

(2) The death of the recipient does not abate any right of action established by this chapter.

(3) (a) No insurance policy issued or renewed after June 1, 1981, may contain any provision that limits the time in which the department may submit its claim to recover medical assistance benefits to a period of less than 24 months from the date the provider furnishes services or goods to the recipient.

(b) No insurance policy issued or renewed after April 30, 2007, may contain any provision that limits the time in which the department may submit its claim to recover medical assistance benefits to a period of less than that described in Subsection (1)(a).

(4) The provisions of this section do not apply to Section 26-19-13.5.

(5) The provisions of this section supercede any other sections regarding the time limit in which an action shall be commenced, including Section 75-7-509.

(6) (a) Subsection (1)(a) extends the statute of limitations on a cause of action described in Subsection (1)(a) that was not time-barred on or before April 30, 2007.

(b) Subsection (1)(a) does not revive a cause of action that was time-barred on or before April 30, 2007.

(7) An action described in Subsection (1)(a) may not be commenced if the claim for recovery or payment described in Subsection (1)(a)(i) is submitted later than three years after the day on which the health care item or service upon which the claim is based was provided.

Amended by Chapter 297, 2011 General Session

26-19-9. Employee benefit plans.

As allowed pursuant to 29 U.S.C. Section 1144, an employee benefit plan may not include any provision that has the effect of limiting or excluding coverage or payment for any health care for an individual who would otherwise be covered or entitled to benefits or services under the terms of the employee benefit plan based on the fact that the individual is eligible for or is provided services under the state plan.

Enacted by Chapter 145, 1993 General Session

26-19-9.5. Availability of insurance policy.

If the third party does not pay the department's claim or lien within 30 days from the date the claim or lien is received, the third party shall:

(1) provide a written explanation if the claim is denied;

(2) specifically describe and request any additional information from the department that is necessary to process the claim; and

(3) provide the department or its agent a copy of any relevant or applicable insurance or benefit policy.

Enacted by Chapter 72, 2004 General Session

26-19-9.7. Legal recognition of electronic claims records.

Pursuant to Title 46, Chapter 4, Uniform Electronic Transactions Act:

(1) a claim submitted to the department for payment may not be denied legal effect, enforceability, or admissibility as evidence in any court in any civil action because it is in electronic form; and

(2) a third party shall accept an electronic record of payments by the department for medical services on behalf of a recipient as evidence in support of the department's claim.

Enacted by Chapter 72, 2004 General Session

26-19-13.5. Estate and trust recovery.

(1) Upon a recipient's death, the department may recover from the recipient's estate and any trust, in which the recipient is the grantor and a beneficiary, medical assistance correctly provided for the benefit of the recipient when the recipient was 55 years of age or older if, at the time of death, the recipient has no:

(a) surviving spouse; or

(b) child:

(i) younger than 21 years of age; or

(ii) who is blind or has a permanent and total disability.

(2) (a) The amount of medial assistance correctly provided for the benefit of a recipient and recoverable under this section is a lien against the estate of the deceased recipient or any trust when the recipient is the grantor and a beneficiary.

(b) The lien holds the same priority as reasonable and necessary medical expenses of the last illness as provided in Section 75-3-805.

(3) (a) The department shall perfect the lien by filing a notice in the court of appropriate jurisdiction for the amount of the lien, in the same manner as a creditor's claim is filed, prior to final distribution.

(b) The department may file an amended lien prior to the entry of the final order closing the estate.

(4) Claims against a deceased recipient's inter vivos trust shall be presented in accordance with Sections 75-7-509 and 75-7-510.

(5) Any trust provision that denies recovery for medical assistance is void at the time of its making.

(6) Nothing in this section affects the right of the department to recover Medicaid assistance before a recipient's death under Section 26-19-4.5 or Section 26-19-13.7.

Amended by Chapter 366, 2011 General Session

26-19-13.7. Recovery from recipient of incorrectly provided medical assistance.

The department may:

(1) recover medical assistance incorrectly provided, whether due to administrative or factual error or fraud, from the recipient or his estate; and

(2) pursuant to a judgment, impose a lien against real property of the recipient.

Enacted by Chapter 145, 1998 General Session

26-19-14. Insurance policies not to deny or reduce benefits of persons eligible for state medical assistance -- Exemptions.

(1) A policy of accident or sickness insurance issued or renewed after May 12, 1981, may not contain any provision denying or reducing benefits because services are rendered to an insured or dependent who is eligible for or receiving medical assistance from the state.

(2) After May 12, 1981, no association, corporation, or organization may deliver, issue for delivery, or renew any subscriber's contract which contains any provisions denying or reducing benefits because services are rendered to a subscriber or dependent who is eligible for or receiving medical assistance from the state.

(3) After May 12, 1981, no association, corporation, business, or organization authorized to do business in this state and which provides or pays for any health care benefits may deny or reduce benefits because services are rendered to a beneficiary who is eligible for or receiving medical assistance from the state.

(4) Notwithstanding Subsection (1), (2), or (3), the Utah State Public Employees Health Program, administered by the Utah State Retirement Board, is not required to reimburse any agency of state government for custodial care which the agency provides, through its staff or facilities, to members of the Utah State Public Employees Health Program.

(5) This section is subject to the provisions of Subsection 31A-22-610.5(3).

Amended by Chapter 102, 1995 General Session

26-19-15. Attorney general or county attorney to represent department.

The attorney general or a county attorney shall represent the department in any action commenced under this chapter.

Amended by Chapter 34, 1984 General Session

26-19-16. Department's right to attorney's fees and costs.

In any action brought by the department under this chapter in which it prevails, the department shall recover along with the principal sum and interest, a reasonable attorney's fee and costs incurred.

Enacted by Chapter 126, 1981 General Session

26-19-17. Application of provisions contrary to federal law prohibited.

In no event shall any provision contained in this chapter be applied contrary to existing federal law.

Amended by Chapter 34, 1984 General Session

26-19-19. Direct payment to the department by third party.

(1) Any third party required to make payment to the department pursuant to this chapter shall make the payment directly to the department or its designee.

(2) The department may negotiate a payment or payment instrument it receives

in connection with Subsection (1) without the cosignature or other participation of the recipient or any other party.

Enacted by Chapter 145, 1998 General Session